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ABSTRACT

The process of promoting behavior change in children described as being immature or antisocial with conduct or behavioral disorders can be enhanced by training their parents in operant techniques in an outpatient clinic setting. Most parents can respond to training because a theoretical understanding of operant techniques is not a prerequisite for being able to perform behavioral techniques. Parent training can be categorized into three types of approaches: educational groups, individual consultation, and controlled learning environments such as workshops. The treatment of choice, based on individual need, is often a combination of group and individual, and home- and office-based instruction. Parental resistance to the training is the major reason for program failure, and includes such factors as guilt, feelings of inadequacy, psychopathology within the family or marital relationship, and difficulty in complying with details. Counselor sensitivity to parental feelings is necessary if effective remediation is to occur. (Author/HLM)

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Promoting Behavior Change using Operant Techniques in an Outpatient Clinic

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PROMOTING BEHAVIOR CHANGE USING OPERANT TECHNIQUES IN AN OUTPATIENT CLINIC

Although the science of behavior modification is well-developed, the artistic and effective application of behavioral principles is sometimes poorly developed. It has only been during the last 15 years that operant behavioral techniques for children had been actively discussed in the literature for training parents to become behavior modifiers of their children (Berkowitz & Graziano, 1972; Johnson & Katz, 1973; O'Dell, 1974). Under the guidance of a psychologist in an outpatient clinic, parents are trained to become inexpensive and continuous therapeutic resources to their children within the home, the child's natural environment. Many therapeutic hours can be generated by training parents to become "therapists" to their own children. This method frees up the professional's time for other endeavors. The purpose of this paper is to discuss the process of promoting behavior change in children by training their parents operant techniques in an outpatient clinic. Although the specific content of the behavior modification techniques will not be enumerated, the broad application of these techniques under various modalities will be discussed. In addition, parental resistances which probably account for the majority of therapeutic failures will be addressed. This paper will focus primarily on children who are described as being immature or antisocial with a conduct or behavioral disorder; children who are psychotic, retarded or grossly emotionally disturbed will not be discussed.

Parent training in operant techniques have been used in a wide variety of problem behaviors in children. Besides showing dramatic behavior changes with problem children, parent training programs have been shown to reduce the rates of deviant behavior in siblings (Arnold, Levine, & Patterson, 1975), as well as increase the overall family cohesion (Karoly & Rosenthal, 1977). Each parent training program varies as to the depth of basic behavioral and learning theory that is imparted to parents. Many parents are directly trained behavioral principles either verbally or with programmed texts (Barrett, 1969; Becker, 1971; Mathis, 1971; Patterson, Cobb, & Ray, 1972; Patterson & Gullion, 1968) but it is questionable if this kind of theoretical depth is needed. In a recent study (O'Dell, Flynn & Benlolo, 1977), parents with problem children were assigned to pre-workshop conditions of either didactic pretraining in basic behavioral principles or one of two control groups. The results showed that parents receiving basic behavior modification pretraining showed no significant outcome differences in relation to the effectiveness of the behavioral program when compared to parents who did not receive the training. The most effective methods of training from the literature appears to be direct training of parents on concretely "how to" modify their child's behavior within the context of a laboratory or workshop format (Bernal, Duryee, Pruett & Burns, 1968; Engeln, Knutson, Laughy, & Garlington, 1968; Johnson & Brown, 1969; Mira, 1970; Rose, 1969). A large part of this training appears to be modeling of the professional by the parent. Direct modeling during parent training in operant techniques has been shown to be one of the most successful training techniques (O'Dell, 1974). Videotape techniques have been shown to be extremely effective in this regard (Bernal, 1969; Bernal, Duryee, Pruett & Burns, 1968; Feighner & Feighner, 1978).

Controversy exists as to what types of parents benefit from parent behavior skills training. It has been reported that verbally intelligent and/or highly educated parents benefit more from training programs than parents who are less intelligent or educated (Patterson, Cobb & Ray, 1972; Patterson, Shaw, & Ebner, 1969; Salzinger, Feldman & Pornoy, 1970). Recent evidence implies that training success is uncorrelated with parental intelligence or education (Mira, 1970; Salzinger et. al., 1970) in tasks which emphasize direct training of skills rather than the verbal learning of principles. In the clinical experience of this author, most parents who can function in our culture as an independent adult can be trained in the use of operant techniques even though they may have little or no understanding of behavioral theory. Theoretical understanding of operant techniques is clearly not a prerequisite of being able to perform behavioral techniques.

Parent training of operant techniques have been categorized into three types of approaches: (1) educational groups, (2) individual consultation, and (3) controlled learning environments (workshops) (Walder, Cohen, Breiter, Daston, Hirsh, & Labowitz, 1969). Although group training is regarded as an extremely cost-efficient method of intervention (Bernal, et. al., 1968; Rinn, Vernon & Wise, 1975) and group intervention is widespread (Bernassi & Bernassi, 1973; Forgatch & Toobert, 1979; O'Dell, Flynn & Benlolo, 1977; Patterson & Gullion, 1968; Rae & Riley, 1976; Rose, 1974; Walder et. al., 1969), evidence exists that under certain conditions, group approaches are more costly than individual consultation (Mira, 1970). A recent study compared group or individual instruction in behavior management techniques. No significant differences between the two groups were found (Hanson, 1975). The issue of whether to give in-

dividual or group instruction to parents is not as important as assessing the individual needs of the parents to determine the best modality to be used. For parents who need peer support or who have children with similar behavior problems, the group modality would be superior to individual consultation. The use of some kind of combination of group and individual instruction that is individually tailored to the parents is the treatment of choice.

The importance of the ability to generalize from the operant techniques to the child's natural environment would strongly argue for the training of behavior modification skills to parents at home rather than in the therapist's office (Bernassi & Bernassi, 1973; Wehman, Abramson & Norman, 1977). Combined home and office training programs have been very popular and have been successful (Johnson & Katz, 1973). A recent study compared the effectiveness of home-based and office-based training of behavior modification skills. No significant differences in treatment outcomes were found, although the home training method was twice as costly in terms of therapist's time (Marton, 1977). In addition, the office-based treatment method appeared to enhance the therapist's placebo effects. Although this controversy is not resolved, the merits of the home-based treatment program where the therapist observes the child's behaviors within the context of naturally occurring reinforcement contingencies cannot be denied. A combination of home- and office-based training would appear to be the treatment of choice if tailored to the individual needs of the parents.

The use of contingencies and extrinsic reinforcers with parents has been shown to be very helpful in increasing their involvement and motivation in learning operant techniques. The majority of these training programs have utilized a reduction in fee to encourage participants (Bernassi &

Bernassi, 1973; Patterson, McNeal, Hawkins & Phelps, 1967; Rinn et. al., 1975). In addition, additional time with the therapist (Mira, 1970; Patterson et. al., 1972) and social reinforcement of the parents' attendance by the therapist (Rose, 1969) have also been successful. These are powerful operant techniques that can be utilized to facilitate positive outcome of a treatment program, but are rarely utilized to the fullest extent.

Although much has been written in the last 15 years concerning training of operant techniques to parents, the research in this area is inadequate to allow us to make any firm conclusions (Johnson & Katz, 1973; O'Dell, 1974). Comparing many of the different approaches to training parents is difficult because each researcher has his own individual definition and description of his particular training program. In addition, most of the studies lack long-term follow-up of the child's behavior which would give clues to the efficacy of the particular method.

No matter how well a behavioral intervention is planned, the program often is not as successful as expected. Parental resistances which result in the sabotaging of treatment is probably the major reason for the program not living up to expectations. Numerous reasons account for parental resistances which greatly reduce the power and efficacy of the operant treatment in the outpatient clinic.

Parental guilt is probably the outstanding reason why operant techniques do not work as well as expected. Even the most blameless parent feels responsible for his child's behavioral disorders and feels guilty that it has not been remediated. Parents will often probe the therapist relentlessly in order to ascertain what they have done to create the current behavior problem in their child. Traditional therapy has done much to support the "blame-a-parent" theory of psychopathology, although behavior therapy can also contri-

bute to this situation. By teaching parents that they can actively alter their child's behavior, it is only a small logical step for the parent to realize that they could have originally precipitated their child's behavior problems. With such overwhelming guilt, parents often have difficulty following a therapeutic program because the program adds to their sense of guilt. In using such things as negative reinforcers, they are punishing the child for something that they feel is their "fault". Thus, parental guilt either renders the parent impotent to act in modifying the child's behavior, or it diverts attention away from the behavioral program because the parents focus on the reason behind their child's behavior, rather than working on the program.

Another parental resistance involves the parent feeling extremely inadequate to effectively manage their child. These feelings are exascerbated by the overt act of bringing their child to a therapist. The pride centered around being an adequate parent is threatened when the parents have to admit that their child is behaving so inappropriately as to necessitate professional help. A tremendous amount of anger is often directed at the therapist because the therapist is confronting the parents' inadequacy by telling them how to raise their child. Parental inadequacy is also seen when a relatively uneducated parent begins to feel overwhelmed by the jargon sometimes used by a psychologist. Although the parent will nod his head in acquiescence during the training session, after leaving the therapist's office, little will be understood and the therapist will be blamed for his incompetence. What the psychologist has done is to increase the parents' feelings of inadequacy by his ineffective communication with the parent.

Resistance to the operant program can also be caused by psychopathology within the family or within the marital relationship. On more than one occasion this author has had a behavior modification fail because of subtle underlying dynamics in the family. Sometimes a family system has a need to keep the child in the role of being the deviant member of the family. The family has an unconscious investment in keeping the child deviant because it redirects all the psychological energy of the family to the deviant child and not on the conflicts which are unresolved within the family. Parents are often threatened by the behavior modification program because it is viewed as being powerful enough to possibly change the entire reinforcement pattern within the family by eliminating the "identified patient" (Satir, 1967). Instead of opening up the family for that kind of revolution, the operant program is often sabotaged. In the same way, behavior modification programs are often sabotaged because of a dysfunctional marital relationship. The child's father and mother may often disagree about how the principles of the operant program should be applied. This results in a lack of consistency which is essential to behavioral programs. In a dysfunctional marriage, the child can be the pawn in a game of manipulation by both parents. These problems are heightened by the fact that in most cases mothers tend to be the focus of training. Fathers may feel that they cannot participate fully in the therapeutic program; their untrained input is not needed. These dynamics can lead to greater parental inconsistency which will result in an ineffective program.

Compliance with the details of an operant program is often difficult for parents. Although parents initially comply with all directions of the therapist, motivation sometimes dissipates as time goes by. In their desire

to obtain quick results, parents often cut corners without regard to the rules of the behavior modification program. This departure from proper procedure can lead to inconsistent modification procedures and thus an ineffective program. When the program does not work, parents understandably lose interest in the program. In the same way, when parents do get quick, impressive results in the initial stages of the program, they feel they need not comply with the behavioral rules so stringently. After all, the problems are observed to no longer exist. Of course, by not following through consistently with the program over the long run, they insure that it will not work. Parents show a tremendous resistance to continuing with the operant program when the results are not as good as they expect.

It is crucial for the therapist to choose effective reinforcers in order for the operant program to work. Because research has shown that many reinforcers are situationally specific (Forehand, Cheney & Yoder, 1974), the office-based therapist is at a real disadvantage at choosing effective reinforcers and often makes mistakes. When parents see that the operant program is ineffective at modifying their child's behavior, they often withdraw from the program. In addition, parents are often philosophically opposed to operant techniques. Parents can feel that positive reinforcement is "bribery", or that transforming the previously regarded "rights" into "privileges" which must be earned is akin to being a tyrant (Stuart, 1971). Many parents feel this shift in policy is not congruent with their own self-image of being a parent, and as a result, they may resist applying such contingencies in an operant program.

Operant techniques are effective in changing children's behavior in an outpatient clinic, although the effectiveness can be enhanced by utilizing some of the principles reviewed in this paper. Little systematic research

has been undertaken to understand the role of parental resistances even though most clinicians agree that these dynamics are extremely powerful. The lack of blending of behavioral orientations with an acknowledgement of underlying dynamics can be traced to the dissimilar philosophies between behavioral and feeling-oriented therapies (Gainer, 1976). Instead of dishing out operant techniques cafeteria-style, sensitivity to the underlying feelings of parents must be taken into account if effective remediation of the behavioral difficulties of children is to take place.

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